VERMONT
DEPARTMENT OF HEALTH

Perinatal Hepatitis B Prevention Program Infant Information Form

The Vermont Department of Health follows up on all reports of pregnant women who test + for hepatitis B surface antigen, and the infants of these women to ensure that they receive the appropriate and recommended vaccines.

PLEASE REPORT ONLY BABIES BORN TO HBsAg POSITIVE MOTHERS- In case of multiple births, use one form for each live birth
(Please include copy of lab slip)

Mother's Name: _____
Last First Middle

Mother's Address: _____

_____ **Phone No:** _____

Name and Address of Physician Who Will Provide Care to Infant after Hospital Discharge:

Name: _____

Address: _____

_____ Phone No: _____

Infant Information:

Name: _____
Last First Middle

Date of Birth: _____/_____/_____ Sex: Male ( ) Female: ( )
Month Day Year

Vaccine Information:

HBIG Given: Yes ( ) No ( ) Date Given: _____/_____/_____
Month Day Year

How many **hours** after birth was HBIG given? _____ hours

HBV1 Given: Yes ( ) No ( ) Date Given: _____/_____/_____
Month Day Year

How many **hours** after birth was the first dose of hepatitis B vaccine given? _____ hours

Name of Hospital: _____

Address: _____

_____

Form completed by: (Please Print)

_____

Phone #: _____

05/05

✉ **PLEASE RETURN FORM TO:**

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